STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015473	A. BUILDING: _____ B. WING _____	C 03/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT QUINCY	1707 NORTH 12TH STREET QUINCY, IL 62301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	COMMENTS Investigation of complaint #1320826/IL61879 - Section 340.1440 f) cited Investigation of complaint #1320893/IL61965 - Section 340.1505g) cited Investigation of complaint #1320671/IL61690	Z 000		
Z9999	FINDINGS LICENSURE VIOLATIONS: 340.1440f) Section 340.1440 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) This requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to keep one resident (R2) reviewed in a sample of six, free from two assault events within a 30 hour period by another resident. Findings include: Facility investigation dated 3-4-13 states "On	Z9999		

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2-27-13 (R2) sustained a laceration to the area below his right lip (by R3) ...Laceration resulted in need of 3 sutures to area. On 2-38-13 (R2) was struck again by aggressor (R3) which resulted in a reopening of the sutured lip and a laceration below his chin. ..Laceration to lip required re-suturing and laceration to chin required 5 sutures."
E31's (RN/Registered Nurse) investigative statement dated 2-27-13 , shows R2 was found with blood to his lip. This investigation shows another resident said R3 hit R2 and said R3 had tried to hit him also. E31 stated R3 had been to the nurse's station saying "I am having trouble with that guy that yells all the time." E31 stated she asked R3 why he hit R2 and R3 stated "that is what I do." E31 told R3 he should not hit others and R3 responded "I will if they cause trouble for me." E31 stated R2 sustained a laceration below his right lip. E31 stated at that time, R2 "continues to yell out and appears afraid and startled when approached covers face with arms."
On 3-8-13 at 10:00 am, R2 was in bed with a laceration to his chin and right lip area. R2 was unable to answer any questions related to the above incidents.
On 3-2-13 at 10:30 am, E20 (RN/Registered Nurse) stated on 2-27-13, between 4 - 4:30 pm, R3 went into R2's room and hit R2 in the mouth. R2 was sent to the hospital for treatment. E20 stated R2's room was close to R3 ' s room and sometimes R3 would get upset with R2's yelling. E20 stated this was a change in character for R3 stating R3 had not been physically aggressive in the past. The next morning, R3 was restless and agitated. R3 was moved to the opposite end of the hall from R2 on 2-28-13. R3's physician was contacted and R3 sent to the emergency room for evaluation with no medical findings. On 2-28-13,

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E20 stated shortly after R3 returned from the emergency room, R3 again went down into R2's room and struck R2 the second time leaving a laceration below his chin and reopening the sutures on his lip. R2 was sent to the emergency room and R3 was put on one to one observation until he was transferred to another unit. E20 stated R3 was not on one to one precautions or 15 minutes checks upon his return from the hospital, before the second assault on R2.
R3's nursing notes dated 2-27-13 at 3:30 pm states "According to (another resident) (R3) hit (R2) causing open area below his right lip. When questioned, (R3) states "if they give me trouble, I hit them that's what I do." R3 ' s nursing notes dated 2-28-13 at 9:50 am state "member aggressive and combative with staff. Attempted to urinate on a resident. Staff redirected, offered to toilet (R3) began swinging fist trying to hit staff. Cursing ..."
R3's face sheet shows R3 has Alzheimer's Disease and Dementia. R3's current MDS (Minimum Data Set) dated 12-19-13 shows R3 has problems with cognition and tends to wander per self. R3 ' s current care plan dated 1-3-13 shows R3 wanders the unit freely, is to have his whereabouts verified every 60 minutes and is to be observed for changes in mood or behaviors.
On 3-12-13 at 11:00 am, E5 (Unit Supervisor) stated on 2-27-13 around 4:00 pm as E5 was leaving the unit, E22 (RN) told him R3 had hit R2. E22 indicated it was no big deal so E5 left the unit. On 2-28-13, E5 received a phone call stating R3 was verbally aggressive. R3 was then assessed by the physician and sent to the emergency room for evaluation. Upon his return to the unit, R3 was up ambulating per self around the unit. At 3:30 pm, E5 was at the desk and heard someone say "(R3) hit him (R2) again." E5 immediately put R3 on one to one and sent

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R2 to the hospital for treatment. E5 stated R3 was not on one to one at that time and did not have specific staff assigned to monitor R3. When asked what he expected his staff to do for monitoring of R3 before the second incident, E5 stated he would expect charting every shift and a behavior sheet to be started. E5 stated he would not expect 15 minutes checks or one to one to be implemented as this was the first incident for R3, even though R3 had been agitated and verbally aggression that morning as well. E5 stated per facility policy, R3 should have been evaluated immediately after the first incident.
On 3-2-13 at 3:15 pm, E23 (VNAC/Veteran's Nursing Assistant Certified) stated on 2-28-13 about 3:45 pm, E23 was down R2's hallway assisting another resident. When E23 came into the hallway, she saw R3 leaving R2's room. R3 had blood on his hand. E23 asked R3 what happened and R3 responded " I busted him. " E23 found R2 in his room with blood on his face. E23 stated no one was with R3 when this incident occurred. E23 stated R2 yells out a lot which irritates R3.
On 3-2-13 at 3:30 pm, E24 (VNAC) stated R3 tends to wander about the unit going in and out of other resident ' s room. E24 stated R3 has had verbal altercations with other residents sometimes threatening to hit residents who are in his way.
On 3-2-13 at 3:35 pm, E25 (VNAC) stated R2 is dependent on staff, uses a wheelchair which he cannot maneuver, and often yells out. E25 stated R3 does get upset with residents who yell out sometimes threatening to "kick butt."
Facility's Abuse policy revised 12/12 states "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility ...Physical Abuse - The use of physical force that can result in

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Z9999	Continued From page 4 bodily injury, physical pain or impairment. When an investigation shows credible evidence that another resident is the perpetrator of abuse against a facility resident, the resident committing the abuse will immediately be evaluated to determine the most suitable therapy and placement for the resident considering the safety of that resident, other residents and employees of the facility." (B) Section 340.1505 Medical, Nursing and Restorative Services g) All necessary precautions shall be taken to assure that the resident's environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide supervision to prevent elopement of one of three residents (R1) reviewed for elopement in the sample of six. Findings include: An Admission Physician Order Sheet dated 2/27/13, documents R1 was has diagnoses which include Dementia with agitation, Insomnia, Hypertension, Hyperlipidemia, and Chronic Kidney Disease. A Minimum Data Sheet dated 3/6/13, documents R1 scored three out of fifteen on the Brief Interview for Mental Status, indicating severely impaired cognitive skills. A Minimum Data Sheet dated 3/6/13, documents R1 wandered daily and was at significant risk of getting to a potentially dangerous place. An Elopement Risk Assessment dated 2/27/13 (admission), documents R1 was an elopement risk.	Z9999		

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An Admission Assessment dated 2/27/13, documents R1 wanders and has a history of insomnia.
A Medication Administration Record dated 3/13, documents R1 resided on a second floor unit from 2/27/13 to 3/6/13.
A Nurses Note dated 2/27/13 at 12:50 p.m., documents R1 ambulates without assistance, is an elopement risk and an electronic monitoring device was applied to R1's left ankle.
A Nurses Note dated 3/2/13 at 9:30 a.m., documents R1 was restless, exit seeking, agitated, and attempting to open windows and push window screens out.
A Physician Progress Note dated 3/2/13 at 3:45 p.m., documents R1 was agitated and "pacing, opening windows, pushing on screens."
Nurses Note dated 3/2/13 through 3/4/13, documents R1 required one on one assistance by staff due to increase behaviors and frequent exit seeking from doors and windows.
On 3/12/12 at 1:30 p.m., E5 (Nursing Supervisor) stated on 3/5/13, a care conference was held in regards to R1 and it was determined R1 seemed to be starting to relax and "acting better." E5 stated R1 was taken off 1:1 supervision, placed on face checks every 15 minutes and required at least twice a shift charting. E5 stated the plan of care, Medication Administration Record, and pertinent charting list were updated to reflect the new interventions.
R1's Care Plan last updated 3/5/13, documents "15 minute face checks and document (every) four hours." R1's Medication Administration Record dated 3/13, documents face check every 15 minutes.
A Nurses Note dated 3/6/13 at 5:30 a.m., documents R1 "has been vigilant in seeking exit from the unit going fire door to fire door. Member ambulates independently and very quickly able to

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cover distances very well."
A Nurses Note dated 3/6/13 at 6:40 a.m., documents R1 had been found outside by a staff member and brought back to the second floor unit. R1 was wearing a t-shirt, pants, socks and slipper socks. R1's electronic device was in place on left ankle. A Nurses Note dated 3/6/13 at 6:50 am., documents R1 was transported to the hospital via ambulance.
On 3/12/13 at 11:35 a.m., E6 (Housekeeping Supervisor) stated she was walking in to R1's building on the first floor front entrance at approximately 6:40 a.m. E6 stated it was just starting to get light outside and the temperature was 23 degrees Farenheit. E6 stated she saw a man standing up against a window of the building. E6 stated she offered the man assistance and the man stated "I need to get to my room." E6 stated at this time she had no idea who this man was or if he was a resident of the facility. E6 stated she reached her hand out to assist the man off the rocked landscaping and observed blood on his hand, forearm, and thumb. E6 stated the man would not move. E6 stated she ran inside the building to get assistance. E6 stated staff came out to assist and it was discovered that the man was R1 from the second floor of the building E6 stated at the time she had no idea R1 had escaped through a second story window. E6 stated R1 was assisted to a wheelchair, wrapped in a blanket and taken back to his unit. E6 stated she and E8 (Registered Nurse) looked around the area where R1 was found. E6 stated the second story breakroom window was open and the screen was unlatched at the bottom and flapping in the wind. E6 stated there was also a gait belt hanging from the window on the outside.
On 3/12/13 at 3:01 p.m., E9 (Registered Nurse) stated he assessed R1 upon returning to the unit on 3/6/13 at approximately 6:45 a.m. E9 stated

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R1 was wrapped in blankets and warm water packs were applied to feet. E9 stated R1's was "hypothermic" with a temperature of 89 degrees Farenheit. E9 stated R1 was secured to a spine board and transferred via ambulance to the Emergency Room due to potential injuries. E9 stated he had last observed resident at approximately 6:00 a.m. E9 stated "(R1) was supposed to be on 15 minute checks but I didn't know it. I signed it off but didn't do it." E9 stated he had charted on R1 numerous times during the 11 p.m.-7 a.m. shift on 3/6/13 so there was documentation of his condition and behaviors to help get him moved to a "completely sealed unit." E9 stated "our unit windows come up and also tilt inward by the nurses station.

On 3/13/13 at 6:41 a.m., E10 (Licensed Practical Nurse) stated she worked on R1's hall the 11 p.m.- 7 a.m. shift on 3/6/13. E10 stated she was not aware of the 15 minute face checks on R1.

On 3/13/13 at 6:05 a.m. E8 (Registered Nurse) stated she worked the 11 p.m. to 7 a.m. shift on 3/6/13. E8 stated she had observed R1 at approximately 5:00 a.m.- 5:30 a.m. attempting to get out the "east end door." E8 stated staff redirected R1. E8 stated "I had no idea (R1) was on 15 minute face checks." E8 stated she was notified that R1 was outside on 3/6/13 at approximately 6:40 a.m. E8 stated she went outside to assist with getting R1 back to the unit. E8 stated she did see the screen window from the second story breakroom flapping in the wind and a gait belt hanging out of the window. E8 stated as R1 was assisted through the front doors in a wheelchair the security alarm device sounded the alarms. E8 stated "I knew he must have come out a window." E8 stated she had reported to E3 (Assistant Director of Nursing) on 3/4/13 or 3/5/13 that R1 was exit seeking and was a problem." E8 stated E3 acknowledged R1's

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issues and was trying to get him moved to the secured Alzheimer's Unit.
On 3/12/13 at 12:00 p.m., E4 (Supervisor) stated he was outside R1's unit on 3/6/13 observing the area where R1 was found, after R1 had been taken back to his room. E4 stated he instructed E11 (Certified Veterans Nurse Aide) to go up to the second floor breakroom and see if the door was locked while he stood outside the window. E4 stated E11 went to the breakroom and found the door unlocked, the window open, the screen pushed out at the bottom, and a gait belt hanging from the window approximately 3 feet.
E11's (Certified Veterans Nurse Aide) written statement dated 3/6/13 at 6:45 a.m., documents "found breakroom door opened and window open, screen pushed out and a gait belt hanging out the window."
On 3/12/13 at 1:30 p.m., E5 (Supervisor) stated "we had discussed moving (R1) to (the locked Alzheimer's Unit) but we had already transferred another resident over there that also required one on one supervision." E5 stated he was aware that R1 had attempted opening windows and pushing on screens to attempt exit.
On 3/12/13 at 11:20 a.m., E3 (Assistant Director of Nursing) stated the investigation of R1 being found outside on 3/6/13 has indicated R1 used the second story breakroom window as an escape route. E3 stated unable to determine if the gait belt was used. E3 stated R1's second story unit is considered a "secured dementia unit." E3 stated the breakroom door was left unlocked which allowed R1 access to an unsecured window. E3 stated facility practice is to keep the breakroom door locked at all times. E3 stated the windows in the supply room and the breakroom do not have stoppers on them to keep them from opening more than a few inches. E3 stated she was aware that R1 had been exit

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seeking, including trying to open windows and screens, since admission. E3 verified that R1 was on 15 minute face checks which had not been completed on 11 p.m.- 7 a.m. shift on 3/6/13. E3 stated R1 had not been transferred to the Alzheimer's unit because the unit R1 was located was secure if the breakroom door had been locked per facility standards. E3 stated it is estimated R1 was out of the building without any staff knowledge for 30 minutes.
E12's (Certified Veterans Nurse Aide) written statement dated 3/6/13 at 6:00 a.m., documents while providing care to a resident in room 158 (1st floor), she heard the landscaping gravel outside the window and saw an outline of a person. E12 documented she was startled and went and asked E27 (Registered Nurse) to come and look out the window.
E27's (Registered Nurse) written statement dated 3/6/13 at 6:20 a.m., documents E12 (Certified Veterans Nurse Aide) asked him to come and look out the window of room 158, after E12 had seen an outline of a person and hearing noise in the gravel. E27 documented he went and looked but did not see anything out the window at that time.
A Resident Transfer Form dated 3/6/13 at 1:45 p.m., documents R1 was transferred to the locked Alzheimer's Unit due to "Resident able to elope from current unit (and) requires transfer.
An Elopement Risk Policy (date unknown), documents should any resident make an attempted elopement, the resident will be moved to a secure unit, further assessments be completed and review and update immediately of the care plan for possible changes in care practices.
An Abuse Prevention, Reporting and Investigation Policy dated 12/12, documents Examples of Neglect may include but are not limited to "Lack

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Z9999	Continued From page 10 of supervision of cognitively impaired residents with known elopement risk." On 3/12/13 at 11:30 a.m., the outside area where R1 was found on 3/6/13 was observed. The distance from the second floor breakroom to the ground was approximately 12 feet. The ground under the breakroom window was covered in grey landscaping rock. (B)	Z9999		